STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 8, 9, 10, 11, and 12, 2011 Facility number: 000137 Provider number: 155232 Aim number: 100266140 Survey team: Ginger McNamee, RN, TC Delinda Easterly, RN Betty Retherford, RN Karen Lewis, RN Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 5 Other: 52 Total: 57 Stage 2 Sample: 30 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/16/11 Cathy Emswiller RN	F0000	Submission of this Plan of correction does not constitute an admission to or an agreement with facts alleged on the survey report Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure each resident's family and/or physician was contacted when there was a change in the resident's condition with a possible need to commence a new	F0157	**F157 NOTIFY OF CHANGES** 1A. THE PHYSICIAN FOR RESIDENT #19 HAS BEEN UPDATED ON OPEN AREAS. 1B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENTS CURRENTLY REVIEWED AND	08/29/2011

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	form of treatment for 2 of 30 residents reviewed for family/physician notification in a Stage 2 Sample of 30. (Resident #19 and #18) Findings include: 1.) The clinical record for Resident #19 was reviewed 8/11/11 at 3:00 p.m. Diagnoses included, but were not limited to, atonic bladder, urinary retention, diabetes mellitus, hypertension, and history of urinary tract infection. A nursing note entry, dated 6/10/11 at 11:00 p.m., indicated the following: "Res [resident] c/o [complained of] areas on right et [and] left buttocks being very sore. Upon examining areas, this nurse noted open areas to each buttock et rewrote previous order for Optifoam to be used to cover open areas until resolved. Order faxed, TAR [treatment administration record] updated. Will continue to monitor." The nursing notes lacked any contact with the physician regarding the resident developing two open areas prior to the nurse writing the order.		ALL TREATMENT ORDERS ARE APPROPRIATE. 1C. THE FACILITY'S POLICY FOR PHYSICIAN/ NOTIFICATION HAS BEEN REVIEWED AND NO CHANGES WERE INDICATED AT THIS TIME. THE NURSES HAVE BEEN RE-EDUCATED ON PHYSICIAN NOTIFICATION. (ATTACHMENT A) 1D. THE DON/DESIGNEE WILL REVIEW THE PHYSICIAN ORDERS ON SCHEDULED WORK DAYS TO ENSURE NOTIFICATION IS COMPLETED TIMELY (ATTACHMENT B) 2A. THE PHYSICIAN AND FAMILY FOR RESIDENT #18 HAVE BEEN UPDATED ON CONDITION CHANGES. 2B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL NURSES NOTES REVIEWED TO ENSURE PROPER NOTIFICATION FOR ANY CONCERNS. 2C. THE FACILITY'S POLICY FOR PHYSICIAN & FAMILY NOTIFICATION HAS BEEN REVIEWED AND NO CHANGES WERE INDICATED AT THIS TIME. THE NURSES HAVE BEEN RE-EDUCATED ON PHYSICIAN & FAMILY	

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	During an interview on with the Administrator and Consultant RN on 8/12/11 at 10:00 a.m., additional information was requested related to the nurse writing the treatment order noted above without contacting the physician. The facility failed to provide any additional information as of exit on 8/12/11. 2.) The clinical record for Resident #18 was reviewed on 8/11/11 at 2:00 p.m. Diagnoses for Resident #18 included, but were not limited to, hypertension, chronic urinary tract infection with urinary retention, dementia, osteoporosis, and transient ischemic attacks. During an interview on 8/8/11 at 2:10 p.m., a concerned family member for Resident #18 expressed concerns over the facility not contacting them when the resident was known to have a condition change. A nursing note, dated 7/2/11 at 8:30 a.m., indicated "Res b/p [blood pressure] 111/73, p [pulse] 73-at med		NOTIFICATION. (ATTACHMENTA) 2D. THE DON/DESIGNEE WILL REVIEW THE PHYSICIAN ORDERS ON SCHEDULED WORK DAYS DAILY TO ENSURE NOTIFICATION IS COMPLETED TIMELY. THIS MONITORING WILL BE ONGOING (ATTACHMENT B) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS CORRECTION DATE: AUGUST 29, 2011	

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	pass-at 7:00 a.m. at 7:45 Res in w/c [wheelchair] slouching and unresponsive-responded to chest rub-b/p 74/52, p 60, r [respiration] 16, taken to room and feet elevated - Sats [oxygen saturation] 96%- at 8:30 a.m. B/p 111/51, p 61, resp [respirations] 16- res drank some of her shakes and was alert and oriented, up in w/c to lunch, ..." The nursing note entry lacked any information related to contact with the resident's physician and/or family related to the unresponsive episode noted above. A nursing note, dated 7/19/11 at 8:30 a.m., indicated "Restorative therapy reports to write of res being weak. CNAs helped res to bed. V/S [vital signs] taken. T. [temperature] 97.9, p 40 weak, r 16, b/p 76/40. Res A/O [alert and oriented] per self just groggy.... Will cont [continue] to monitor." The next nursing note, dated 7/19/11 at 10:35 a.m., indicated "Res daughter notified, left message regarding res fiber drink." The nursing notes lacked any information related to the physician having been notified of the residents			

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	weakness episode with low pulse and b/p noted above. The notes did not indicated if the resident's daughter was aware of the weakness episode and not just the new order for a fiber drink which had been received on 7/18/11. During an interview on with the Administrator and DoN on 8/12/11 at 8:25 a.m., additional information was requested related to the lack of physician and family notification of the two episodes noted above occurring on 7/2 and 7/19/11. The facility failed to provide any additional information as of exit on 8/12/11. The current 1/06, "Physician & Family Notification Procedure" was provided by the RN consultant on 8/12/11 at 8:55 a.m. The purpose of the procedure is to keep the physician, resident and family appraised of all condition changes. The procedure indicated the physician was to be notified of any change in condition that may or may not warrant a change in the treatment plan. The information reported to the physician should be documented in the nurses notes along with the physician's response. The procedure indicated the resident and responsible party			

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	should be notified of any change in condition that may or may not warrant a change in treatment plan. 3.1-5(a)(2) 3.1-5(a)(3)			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on record review and interview the facility failed to ensure the resident was treated with dignity during incontinent care and was spoken to in a manner that maintained dignity for 1 of 10 residents who were interviewed related to dignity issues in a stage 2 sample of 30 (Resident #73) Findings include: The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to, diabetes mellitus, morbid obesity and osteoarthritis. **Resident #73 had a healthcare plan, dated 6/24/11 which indicated**	F0241	**F 241 DIGNITY AND RESPECT OF INDIVIDUALITY** 1.RESIDENT #73 WAS IMMEDIATELY INTERVIEWED AND MENTAL ANGUISH COMPLETED WITH NO NEGATIVE OUTCOME. 2.ALL OTHER RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. THEY HAVE BEEN OBSERVED AND THEY HAVE BEEN INTERVIEWED IF ABLE TO ENSURE THERE ARE NO DIGNITY CONCERNS. 3.THE RESIDENT HANDBOOK FOR RESIDENT RIGHTS/ABUSE HAS BEEN REVIEWED AND NO CHANGES INDICATED AT THIS TIME. ALL STAFF HAVE BEEN RE-EDUCATED RELATED TO ABUSE/RESIDENT RIGHTS/DIGNITY. (ATTACHMENT C) 4. THE SSD/DESIGNEE WILL INTERVIEW 5 ALERT AND ORIENTED(THIS WILL INCULDE RESIDENTS WHO	08/29/2011

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	the resident had a problem listed as, the resident is dependent upon 2 staff for activities of daily living. Interventions for this problem included, provide perineal care after each incontinent episode. **An admission Minimum Data Set Assessment, dated 6/21/11, indicated Resident #73 was totally dependent upon the staff for toileting, and bed mobility and the resident was frequently incontinent of her bowels.** **During an interview on 8/8/11 at 9:22 A.M. Resident #73 indicated the staff who cared for her did not treat her with dignity and respect. The resident indicated the staff were not gentle and were sometimes "rough" when they cleansed her buttocks and perineal area following incontinent diarrhea episodes. The resident also indicated a physical therapist would get mad at her when she could not complete the exercises the therapist recommended. The resident indicated the therapist would sometimes raise her voice and spoke in an unkind manner. The resident indicated she "dreaded" to go to therapy.**		ARE RECEIVING THERAPY SERVICES) & THE DON/DESIGNEE WILL COMPLETE PERI CARE AUDITS FOR RESIDENTS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS TO ENSURE THERE ARE NO DIGNITY CONCERNS. (ATTACHMENT D) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	During an interview with the facility Administrator on 8/8/11 at 9:45 a.m. she indicated the facility was unaware of any complaints Resident #73 had related to her care. The Administrator indicated she was unaware of the above incidents. She further indicated the facility would investigate the above complaints . 3.1-3(t)			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to ensure a resident received activities which interested her for 1 of 10 residents who were interviewed related to activities in a Stage 2 sample of 30 (Resident #73). **Findings include:** The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to,	F0248	**F248 ACTVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT** 1.RESIDENT #73 HAS BEEN RE-ASSESSED BY THE ACTIVITY DIRECTOR TO ASSURE ALL ACTIVITIES OF INTEREST HAVE BEEN MET. 2.ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ACTIVITY DIRECTOR/DESIGNEE HAS COMPLETED ACTIVITY QUESTIONNAIRE	08/29/2011

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	diabetes mellitus, morbid obesity and osteoarthritis. **Resident #73 had a healthcare plan, dated 6/15/11, which indicated the resident had a problem/strength listed as, resident establishes her own goals by deciding how to spend her leisure time. Resident sits in lounge area 2-3 times weekly and socializes with her peers and people watches. The goal for this problem/strength was for the resident to maintain her current level as evidenced by attending 1-2 activities each week thru the next review. Interventions listed were, provide a monthly calendar of activity events, remind resident of activities of choice and interests such as special events and social hour, offer to escort resident to and from activities of choice and interest, and offer and assist in materials for independent activities of interest.** **Resident #73 had a healthcare plan, dated 6/15/11 which indicated the resident had a problem listed as, resident exhibits depressive symptoms such as being withdrawn. Interventions for this problem included, provided 1:1's**		FOR ALL RESIDENTS TO ASSURE INTERESTARE ACCURATE. (ATTACHMENT E) 3.ACTIVITY DIRECTOR/ACTIVITY ASSISTANT HAVE BEEN EDUCATED ON PROPER DOCUMENTATION AS WELL AS ASSURING INTERESTS ARE CURRENT. (ATTACHMENT F) 4.ACTIVITY DIRECTOR/ DESIGNEE WILL INTERVIEW 3 INDIVIDUALS ON SCHEDULED DAYS OF WORK AS FOLLOWS DAILY TIMES ONE WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY 3 MONTHS TO ENSURE INTERESTS ARE CURRENT. THE DON/DESIGNEE WILL MEET WITH THE CONSULTANTING PHARMACIST DURING VISITS TO INFORM THEM OF NEW ADMISSIONS AND WILL REVIEW THEIR REPORT TO ASSURE ISSUES ADDRESSED IMMEIDATELY. RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS.	

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	as needed and encourage activities of choice and interest. **Review of an "Initial Activity Assessment" form, dated 6/14/11 indicated Resident #73 had the following interests and hobbies listed; bingo, listening to gospel and country music, pet visits, people watching, parties, special events, and reading newspapers and magazines.** **During an interview with Resident #73 on 8/8/11 at 9:30 a.m., the resident indicated the facility did not provide her with any activities which were of interest to her. The resident indicated she spent most of her time in her room in the bed. The resident indicated the activity staff had not provided her any books, newspapers and or magazines to read.** **During observation on the following dates and times Resident #73 was in her room in her bed with no books, newspapers or magazines observed in the resident's room,** **A. 8/8/11 at 9:30 A.M.**		CORRECTION DATE: AUGUST 29, 2011	

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	B. 8/8/11 at 2:30 p.m. **C. 8/9/118/3/11 at 9:00 a.m.** **D. 8/9/11 at 1:20 p.m.** **During an interview with the Activity Director on 8/10/11 at 1:20 p.m. information was requested related to the activity staff having provided activities of interest for Resident #73 to complete in her room.** **During an interview with the Activity Director on 8/11/11 at 9:00 A.M. she indicated when the resident was admitted the facility in June she attended group activities out of her room. She further indicated the resident had a decline in her condition and had not been attending any group activities for "quite a while". The Activity Director indicated the activity staff had started 1:1 activities with Resident #73 in August.** **Review of the 1:1 documented visits for Resident #73, provided by the Activity Director on 8/10/11 at 4:15 p.m. indicated,** **8/1/11, 15 minutes, passed**			

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	nourishments **8/2/11, 15 minutes, helped resident with her noon meal** **8/3/11, 15 minutes, passed ice water to resident and conversed about how she felt** **8/5/11, 45 minutes, helped with noon meal and watched the news with resident** **During an interview with the Activity Director on 8/11/11 at 9:15 a.m. she indicated the only activities the facility had documented for Resident #73 were the activities listed above.** **During an interview with the Director of Nursing on 8/11/11 at 10:00 A.M. she indicated the activities listed above for Resident #73 were part of the resident's routine care and should not have been listed as an activity.** **3.1-33(a)**			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.			

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	Based on observation and interview the facility failed to ensure resident rooms were properly maintained and in good repair related to non-secured covebase (room122) , walls in poor repair (room 126), closet doors non-functional (rooms 120 and 213), chipped window sill (room 120) and Television cable wiring not secured to the walls (rooms 109, 110 and 112) for 8 of 20 resident rooms observed for environmental concerns (room numbers 109, 110, 112, 122, 126, 120, 213, and 102) Findings include: During the environmental tour on 8/10/11 at 1:30 p.m. with the Maintenance Director and Housekeeping Supervisor the following concerns were identified, A. Room 122, under the wall mounted air conditioner unit, the cove base was detached from the wall. The cove base was detached from the wall in a section approximately 3 feet in length. The wall board was exposed behind the cove base. B. Room 126 several areas of black scuff marks were noted across the walls. The wall board had multiple areas of indentations noted.	F0253	**F253 HOUSEKEEPING & MAINTENANCE SERVICES** 1A. ROOM 122 COVE BASE WAS IMMEDIATELY REPAIRED. 2A. ALL RESIDENT ROOMS HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3A. ALL STAFF HAVE BEEN RE-EDUCATED ON COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS. (ATTACHMENT G) 4A. ADMINISTRATOR/DESIGNEE TO COMPLETE ROUNDS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS TO ENSURE COVE BASE IS SECURED. (ATTACHMENT H) 1B. ROOM 126 THE BLACK SCUFF MARKS WERE REPAIRED AND WALL BOARD REPLACED. 2B. ALL RESIDENT ROOMS HAVE THE POTENTIAL TO BE	08/29/2011

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	C. Room 120 the closet doors were off the tracks and the window sill had a section of Formica that was chipped and missing. D. Room 213 the closet doors were off the tracks. E. Room 102, the footboard of the bed in the "B" bed was rough to the touch and had gouged areas in the Formica. F. Rooms 109, 110 and 112 the cable T.V. cables were run across the room and were stapled to the walls. Some of the cables were loose and dangling in the air. During an interview with the Maintenance Director at the time of the environmental tour, he indicated he was unaware of any of the above concerns. He further indicated he had not received any work orders for these concerns. 3.1-19(f)		AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3B.ALL STAFF HAVE BEEN RE-EDUCATED ON COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS. (ATTACHMENT G) 4B. ADMINISTRATOR/DESIGNEE TO COMPLETE AUDITS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS TO ENSURE WALLS ARE REPAIRED. (ATTACHMENT H) 1C & D. ROOM 120 & 213 CLOSET DOORS WERE IMMEDIATELY REPAIRED. ROOM 120 WINDOW SILL REPLACED D/T CHIPPED FORMICA. 2C & D. ALL RESIDENT ROOMS HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3C & D. ALL STAFF HAVE BEEN RE-EDUCATED ON	

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			COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS. (ATTACHMENT G) 4C& D.ADMINISTRATOR/DESIGNEE TO COMPLETE AUDITS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS TO ENSURE CLOSET DOORS AND NO CHIPS IN FORMICA. (ATTACHMENT H) 1E. ROOM 102 FOOT BOARD WAS REPLACED AND GOUGED FORMICA WAS REPLACED. 2E. ALL RESIDENT ROOMS HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3E. ALL STAFF HAVE BEEN RE-EDUCATED ON COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS. (ATTACHMENT G) 4E.ADMINISTRATOR/DESIGNE E TO COMPLETE AUDITS ROUNDS ON	

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			SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS TO ENSURE FOOT BOARD FREE FROM ROUGH EDGES AND FORMICA NO GOUGED FORMICA. (ATTACHMENT H) 1F. ROOM 109, 110 AND 112 CABLE CORDS WERE IMMEDIATELY RE-SECURED. 2F. ALL RESIDENT ROOMS HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3F. ALL STAFF HAVE BEEN RE-EDUCATED ON COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS TO ASSURE MAINTENANCE DIRECTOR AWARE OF CONCERNS. (ATTACHMENT G) 4F. ADMINISTRATOR/DESIGNEE TO COMPLETE AUDITS ROUNDS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK,	

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			3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS TO ENSURE FOOT BOARD FREE FROM ROUGH EDGES AND FORMICA NO GOUGED FORMICA. (ATTACHMENT H) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure the nursing staff updated the health care plans for 2 of 20 residents reviewed with health care plans in a Stage 2 Sample of 30.	F0280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 1A. THE CARE PLAN FOR RESIDENT #61 & #73 IMMEDIATELY UPDATED.	08/29/2011

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	(Resident #'s 61 and 73) Findings include: 1. The clinical record for Resident #61 was reviewed on 8/10/11 at 2:10 p.m. Current diagnoses for Resident #61 included, but were not limited to, bipolar disorder, chronic back pain, depression, chronic abdominal pain, and history of small bowel obstructions. Resident #61 had a health care plan dated 7/13/11, which indicated the resident had a risk for constipation. An intervention for this problem included monitor bowel sounds daily. Resident #61's clinical record lacked an indication of daily bowel sounds being completed. During an interview with the DoN, on 8/11/11, at 3 p.m., she provided documentation that the daily monitoring of bowel sounds had been discontinued on 10/25/10. The health care plan for Resident #61 had been updated on 1/13/11, 4/13/11, and 7/13/11, and failed to indicate the daily monitoring had been		1B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL NURSING AND ACTIVITY CARE PLANS WERE REVIEWED TO ENSURE ACCURACY. 1C. ALL STAFF HAVE BEEN RE- EDUCATED RELATED PROPER DOCUMENTATION OF CARE PLANS. (ATTACHMENT A) 1D.THE DON/DESIGNEE & ACTIVITY DIRECTOR/DESIGNEE WILL REVIEW CARE PLANS EVERY QUARTER/ANNUALLY AND WITH EVERY CHANGE OF CONDITION TO ENSURE ACCURACY. MEDICAL RECORDS/DESIGNEE WILL AUDIT 3 CHART AUDITS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS TO ENSURE CARE PLANS ARE UP TO DATE. RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS.	

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	discontinued. 2.) The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to, diabetes mellitus, morbid obesity and osteoarthritis. **Resident #73 had a healthcare plan, dated 6/15/11, which indicated the resident had a problem/strength listed as, resident establishes her own goals by deciding how to spend her leisure time. Resident sits in lounge area 2-3 times weekly and socializes with her peers and people watches. The goal for this problem/strength was for the resident to maintain her current level as evidenced by attending 1-2 activities each week thru the next review. Interventions listed were, provide a monthly calendar of activity events, remind resident of activities of choice and interests such as special events and social hour, offer to escort resident to and from activities of choice and interest, and offer and assist in materials for independent activities of interest.**		CORRECTION DATE: AUGUST 29, 2011	

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	Resident #73 had a healthcare plan, dated 6/15/11 which indicated the resident had a problem listed as, resident exhibits depressive symptoms such as being withdrawn. Interventions for this problem included, provided 1:1's as needed and encourage activities of choice and interest. **During an interview with Resident #73 on 8/8/11 at 9:30 a.m., the resident indicated the facility did not provide her with any activities which were of interest to her. The resident indicated she spent most of her time in her room in the bed. The resident indicated the activity staff had not provided her any books, newspapers and or magazines to read.** **During observation on the following dates and times Resident #73 was in her room in her bed with no books, newspapers or magazines observed in the resident's room,** **A. 8/8/11 at 9:30 A.M.** **B. 8/8/11 at 2:30 p.m.**			

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	C. 8/9/118/3/11 at 9:00 a.m. **D. 8/9/11 at 1:20 p.m.** **During an interview with the Activity Director on 8/10/11 at 1:20 p.m. information was requested related to the activity staff having provided activities of interest for Resident #73 to complete in her room.** **During an interview with the Activity Director on 8/11/11 at 9:00 A.M. she indicated when the resident was admitted the facility in June she attended group activities out of her room. She further indicated the resident had a decline in her condition and had not been attending any group activities for "quite a while". The Activity Director indicated the activity staff had started 1:1 activities with Resident #73 in August. The Activity Director indicated she had not updated the resident's activity health care plan since admission to reflect the change in the resident's condition and the possible need to alter the residents activities accordingly.** The 11/08, "Care Plan Development and Review Procedure" policy was			

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	provided on 8/12/11 at 12:35 p.m., by the Administrator. The policy indicated an interdisciplinary team in coordination with the resident and the resident"s family will develop a care plan. The care plan is designed to incorporate identified problem areas; incorporate risk factors associated with identified problems. Care plans are to reflect treatment and objectives in goals. Care plans are revised as changes in the resident's condition dictates. 3.1-35(d)(2)(B)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation, and interview, the facility failed to ensure the nursing staff clarified readmission orders in regards to a Foley catheter and readmission medications for 2 of 4 residents (Resident #'s 9 and 73) reviewed readmitted from the hospital and failed to ensure the nursing staff did not write medication and/or treatment orders without contacting the physician for 2 of 30 residents	F0282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** 1A. RESIDENT #19 OPTIFOAM ORDER WAS REVIEWED WITH PHYSICIAN AND DETERMINED TO BE APPROPRIATE. 1B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENTS CURRENTLY REVIEWED AND ALL	08/29/2011

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	(Resident #'s 19 and 58) reviewed for physicians orders and failed to ensure the nursing staff administered antihypertensive medications and insulin coverage as ordered by the physician for 3 of 20 residents (Resident #'s 71, 73, and 60) reviewed for medication administration in a Stage 2 Sample of 30. Findings include: 1.) The clinical record for Resident #19 was reviewed 8/11/11 at 3:00 p.m. Diagnoses included, but were not limited to, atonic bladder, urinary retention, diabetes mellitus, hypertension, and history of urinary tract infection. A nursing note entry, dated 6/10/11 at 11:00 p.m., indicated the following: "Res [resident] c/o [complained of] areas on right et [and] left buttocks being very sore. Upon examining areas, this nurse noted open areas to each buttock et rewrote previous order for Optifoam to be used to cover open areas until resolved. Order faxed, TAR [treatment administration record] updated. Will continue to		TREATMENT ORDERS APPROPRIATE. 1C. THE NURSES WERE EDUCATED THAT ORDERS MUST BE OBTAINED FROM PHYSICIAN. (ATTACHMENT A) 1D. THE DON/DESIGNEE WILL REVIEW THE PHYSICIAN ORDERS ON SCHEDULED WORK DAYS TO ENSURE PHYSICIAN NOTIFICATION IS COMPLETED TIMELY (ATTACHMENT B) 2A. MEDICATION ERROR REPORT COMPLETED FOR RESIDENT #9 WITH PHYSICIAN NOTIFICATION. 2B.ALL RE-ADMITS HAVE THE POTENTIALTO BE AFFECTED. ALL RE-ADMISSION ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE PROPER TRANSCRIPTION OF ORDERS. 2C. THE NURSES HAVE BEEN RE-EDUCATED ON PROPER TRANSCRIPTION OF ORDERS. (ATTACHMENT A) 2D. ALL RE-ADMISSION ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE PROPER TRANSCRIPTION OF ORDERS. (ATTACHMENT	

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	monitor." The nursing notes lacked any contact with the physician regarding the resident developing two open areas prior to the nurse writing the order. During an interview on with the Administrator and Consultant RN on 8/12/11 at 10:00 a.m., additional information was requested related to the nurse writing the treatment order noted above without contacting the physician. The facility failed to provide any additional information as of exit on 8/12/11. 2.) The clinical record for Resident # 9 was reviewed at 8/11/11 at 9:30 a.m. Diagnoses for Resident #9 included, but were not limited to, chronic leg cellulitis, venous stasis, congestive heart failure, alcoholic liver disease, anxiety , mental retardation and dementia. Resident #9 was readmitted from the hospital on 7/14/11 following treatment for cellulitis, alcoholic liver disease, and diabetes mellitus. Readmission orders sent with the resident included, but were not limited		B) 3A.RESIDENT #71 ASSESSED AND NO HARM NOTED. 3B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. RESIDENTS WITH PRN CLONIDINE ORDERS HAVE BEEN REVIEW TO ENSURE PROPER ADMINISTRATION OF MEDS. 3C. ALL NURSES WERE EDUCATED ON PROPER ADMINISTRATION OF PRN MEDICATIONS. (ATTACHMENT A) 3D. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD PRESSURE ORDERS TO ENSURE PROPER ADMINISTRATION OF PRN MEDICATIONS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) 4A. FOLEY CATHETER ORDER WAS IMMEDIATELY OBTAINED FOR RESIDENT #73 AND GLUCOSE RESULTS WERE OBTAINED FROM 24 HOUR SHEETS AND PLACED ON CHART RECORD.	

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	to, the following three orders as noted below: Levaquin (an antibiotic) 500 milligrams one daily for 21 days (the order indicated this med had been started on 6/16/11, which indicated the medication regimen should have been completed). This order was transcribed to the MAR to be given daily without note of any stop date. The times the medication was to be given were documented in error for twice daily at 7 a.m. and 7 p.m.- The med was given twice daily for three days in error and then rewritten for once daily with a stop date now included for 8/3/11 (a 21 day time period). Fluticasone 0.05 % (a spray used for allergy relief) 2 sprays inhaled daily. This medication was transcribed to the MAR as "Fluticasone 0.5 % nasal spray 2 sprays each nostril daily" The time the medication was to be given was recorded in error for 7 a.m. and 8 p.m., not once daily. This medication was given twice daily through 8/11/11. Saline nasal spray (a moisture nasal spray) 1 spray each nostril several times daily. This medication was transcribed to the MAR as "Saline nasal spray 1 spray each nostril three		4B. ALL RESIDENTS WITH CATHETER ORDERS AND GLUCOSE MONITORING ORDERS WERE REVIEWED. 4C. NURSES WERE EDUCATED ON APPROPRIATE CATHETER ORDERS AND NEW GLUCOSE MONITORING PROCEDURES. (ATTACHMENT A) 4D. ALL CATHETER ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE APPROPRIATE ORDER OBTAINED. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD GLUCOSE ORDERS TO ENSURE PROPER ADMINISTRATION OF SLIDING SCALE ORDERS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS(ATTACHMENT B & I) 5A. NURSE PRACTIONER WAS NOTIFIED OF TYLENOL ORDER FOR RESIDENT #58. 5B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. REVIEW OF CURRENT NURSES NOTES PROVIDED NO INDICATION OF ANY FURTHER ORDERS	

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	times daily." The saline nasal spray was documented as having been given 3 times daily through 8/11/11. The clinical record lacked documentation of the Levaquin, Fluticasone, and/or Saline nasal spray having been clarified with the physician at the time of readmission and/or any other occasion. During an interview with the Administrator and Director of Nursing on 8/11/11 at 1:50 p.m., additional information was requested related to the Levaquin having been given for another 21 days and the errors in the Levaquin, Fluticasone nasal spray, and Saline nasal spray administration as noted above. During an interview with the Director of Nursing on 8/12/11 at 1:30 p.m., she indicated the nasal spray orders above had been clarified. She indicated she was still trying to find out whether the physician intended for the Levaquin to be restarted and given for another 21 days. 3.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included,		WRITTEN WITHOUT PHYSICIAN AUTHORIZATION. 5C. . THE NURSES WERE EDUCATED THAT ORDERS MUST BE OBTAINED FROM PHYSICIAN. (ATTACHMENT A) 5D. THE DON/DESIGNEE WILL REVIEW THE PHYSICIAN ORDERS ON SCHEDULED WORK DAYS TO ENSURE NOTIFICATION IS COMPLETED TIMELY ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B) 6A. GLUCOSE RESULTS WERE OBTAINED FROM 24 HOUR SHEETS AND PLACED ON CHART RECORD FOR RESIDENT #60. 6B. GLUCOSE MONITORING ORDERS WERE REVIEWED. 6C.NURSES WERE EDUCATED NEW GLUCOSE MONITORING PROCEDURES. (ATTACHMENT A) 6D. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD GLUCOSE	

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	155232	A. BUILDING 00 B. WING	08/12/2011

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	but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. A health care plan problem, dated 6/1/11, indicated the resident had a diagnosis of hypertension and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, "Administer medications as ordered" and "Monitor blood pressure as ordered." A recapitulation of physician's orders, dated 7/6/11, indicated Resident #71 was to have her blood pressure taken 3 times daily. The orders indicated the resident was to receive Clonidine 0.1 mg [milligram] one tablet as needed if the resident's systolic b/p [blood pressure] was above 150 and her diastolic b/p was above 90. During a review of the June and July medication administration records (MAR) on the following dates and times, the residents b/p was elevated within the range for the as needed Clonidine to have been given: 6/29/11 at 10 p.m.- 167/98 7/15 at 10 p.m. - 170/94 7/17/11 at 10 p.m.-154/90		ORDERS TO ENSURE PROPER ADMINISTRATION OF SLIDING SCALE ORDERS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	The MAR and nursing notes for these dates and times lacked any information related to the blood pressure medication having been given as ordered by the physician and/or any follow-up blood pressure reading having been taken. The following dates and times lacked any blood pressure having been taken to see if the blood pressure medication needed to be given: June 2 and 3, 2011 at 6 a.m. June 4 and 9, 2011 at 2 p.m. June 10, 13, 14, and 15, 2011 at 6 a.m. June 15, 2011 at 10 p.m. June 17, 19, 20, 21, 2011 at 6 a.m. June 20 and 21, 2011 at 2 p.m. June 30, 2011 at 10 p.m. July 19, 2011 at 10 p.m. July 20, 21, 22, 2011 at 6 a.m. During an interview with the Administrator and Director of Nursing (DoN) on 8/11/11 at 8:20 a.m., additional information was requested related to the lack of medication having been given on the dates noted above or the blood pressure having been taken as ordered on the dates noted above. During an interview on 8/12/2011 at			

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	11:30 a.m., the DoN indicated she had no information to provide related to the medication having not been given and/or the blood pressure having been taken on the dates noted above. 4.) The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to, diabetes mellitus, morbid obesity and osteopathic. Resident #73 was admitted to the facility on 6/14/11. Resident #73 had a health care plan, dated 6/24/11 which indicated the resident had a problem listed as, the resident requires the use of a Foley catheter due to, multiple wounds, incontinent of bowel and morbid obesity. During observation on 8/8/11 at 9:00 a.m. Resident #73 was in her room , in her bed. The resident had an anchored Foley catheter in place. The catheter urinary drainage bag was inside a privacy bag. The catheter was secured on the side of the resident's bed.			

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	Review of Resident #73's clinical record on 8/8/11 at 1:30 p.m. indicated there was no physician's order for the anchored catheter to be continued upon admission to the facility. The transfer orders signed by the hospital physician prior to admission to the facility lacked any order for the anchored catheter to be maintained. **A physician's telephone order, dated 6/25/11 indicated an order to flush the anchored catheter as needed and anchor new catheter if unable to maintain patency of the current catheter in place.** **During an interview with the Director of Nursing on 8/8/11 at 2:00 p.m. she indicated the resident was admitted to the facility from the hospital with a catheter in place. She indicated she could not find an order in the clinical record for the catheter to be maintained following her admission to the facility. The Director of Nursing indicated the nurse who was working when the resident was admitted to the facility should have clarified with the physician at the time of admission any orders for**			

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	the anchored catheter. The clinical record indicated Resident #73 had the following diabetic related physician's orders: A. Metformin (an oral diabetic medication) 500 milligrams 1 orally daily. The original date of this order was 7/10/11. B. Monitor blood glucose levels before meals and at bedtime. 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 6/14/11. July 21, 2011 an order was received to decrease blood glucose monitoring to twice daily 6:30 a.m. and 4:30 p.m. C. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below, 100 -150 = 3 units 151 - 200 = 6 units 201 - 250 = 10 units 251 - 300 = 15 units greater than 300 call the physician. A health care plan, dated 6/4/11 indicated Resident #73 had a problem listed as, the resident has a			

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	diagnosis of diabetes mellitus and is at risk for experiencing hypo or hyperglycemia. Interventions for this problem included, monitor blood sugars as ordered and administer medication as ordered. **Review of the June and July 2011 "Blood Glucose Monitoring Record" forms for Resident #73 indicated the resident received the incorrect dose of insulin on the following dates and times,** **June 22, 4:30 p.m. blood sugar result was 102, no insulin was documented as having been given, the resident should have received 3 units.** **June 26, 6:30 a.m., blood sugar result was 101, no insulin was documented as having been given, the resident should have received 3 units.** **July 13, 6:30 a.m., blood sugar result was 100, no insulin was documented as having been given, the resident should have received 3 units.** **July 14, 9:00 p.m., blood sugar result was 126, no insulin was**			

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	documented as having been given, the resident should have received 3 units. **July 18, 11:30 a.m., blood sugar result was 114, no insulin was documented as having been given, the resident should have received 3 units.** During an interview with the Director of Nursing on 8/11/11 at 3:30 p.m. additional information was requested related to the lack of sliding scale coverage having been documented as given on the dates and time noted above. During an interview with the Director of Nursing on 8/12/11 at 9:00 a.m. she indicated she could not find any documentation to indicate the resident had received any insulin on the dates and times noted above. 5.) The clinical record for Resident #58 was reviewed on 8/10/11 at 2:00 p.m. Resident #58's current diagnoses included, but were not limited to, schizophrenia and chronic pain. A nursing note entry, dated 6/7/11			

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	indicated the following, 6/7/11 3:40 a.m., "Resident requested pain medication for leg and foot pain. Resident had no PRN [as needed] pain meds ordered. Routine hydrocodone [a narcotic pain medication] was not due until 0800 and resident was in obvious pain. Writer used nursing judgement and wrote an order for PRN Tylenol [2] 325 mg [milligrams] q [every] 6 hours for pain, faxed to pharmacy...." A physician's telephone order sheet, dated 6/7/11 and timed for 3:40 a.m., indicated an order for Tylenol 325 mg 2 for pain prn. The order was signed by the nurse. A nursing note entry, dated 6/30/11 at 2:00 p.m. indicated, Nurse Practitioner notified of PRN Tylenol order and order is OK. During an interview with the Director of Nursing on 8/11/11 at 8:30 a.m. she indicated the nurse who had written the above medication order was a nurse who usually worked at the hospital. She further indicated at the hospital the nurse could write an order for Tylenol because there were "standing orders" for the medication. The Director of Nursing indicated at			

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	the long term care facility a nurse could not write any orders. She indicated the physician and or nurse practitioner should have been called and an order received for the Tylenol. 6.) The clinical record for Resident #60 was reviewed on 8/9/11 at 2:10 p.m. Resident # 60's current diagnoses included, but were not limited to, diabetes mellitus and dementia. Resident #60 had a health care plan, dated 4/21/11 which indicated the resident had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypoglycemia and hyperglycemia. Interventions for this problem included monitor blood sugars as ordered and administer medication as ordered. Resident # 60 had physician's orders for the following, A. Monitor blood sugar results 4 times daily at 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 3/31/10 B. Administer Lantus insulin 8 units subcutaneously at bedtime. This			

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	order originated on 2/8/10. C. Administer Novolog sliding scale insulin according to blood sugar results as listed below, 141 - 180 = 1 unit 181 - 220 = 2 units 221 - 260 = 4 units 261 - 300 = 6 units 301 - 340 = 7 units 341 - 380 = 8 units 381 - 420 = 9 units 421 - 460 = 10 units greater than 460 call the physician The sliding scale insulin orders originated on 3/31/10 Review of the July 2011 "Blood Glucose Monitoring Record" for Resident # 60 indicated the incorrect dose of insulin was documented as having been given on the following dates and times, July 1, 11:30 a.m., blood sugar result was 176, no insulin was documented as having been given. The resident should have received 1 unit. July 1, 4:30 p.m., blood sugar result was 171, no insulin was documented as having been given. The resident			

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	should have received 1 unit. July 1, 9:00 p.m., blood sugar result was 143, no insulin was documented as having been given. the resident should have received 1 unit. July 2, 11:30 a.m., blood sugar result was 209, no insulin was documented as having been given. The resident should have received 2 units. July 2, 4:30 p.m., blood sugar result was 234, no insulin was documented as having been given. The resident should have received 4 units. July 2, 9:00 p.m., blood sugar result was 141, no insulin was documented as having been given. The resident should have received 1 unit. July 3, 11:30 a.m., blood sugar result was 243, no insulin was documented as having been given The resident should have received 4 units. July 3, 4:30 p.m., blood sugar result was 226, no insulin was documented as having been given. The resident should have received 4 units. July 4, 11:30 a.m., blood sugar result was 243, no insulin was documented as having been given. The resident			

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	should have received 4 units. July 5, 11:30 a.m., blood sugar result was 145, no insulin was documented as having been given. The resident should have received 1 unit. July 6, 11:30 a.m., blood sugar result was 211, no insulin was documented as having been given. The resident should have received 2 units. July 6, 4:30 p.m., blood sugar result was 160, no insulin was documented as having been given. The resident should have received 1 unit. July 13, 11:30 a.m., blood sugar result was 146, no insulin was documented as having been given. the resident should have received 1 unit. During an interview with the Director of Nursing on 8/11/11 at 3:30 p.m. additional information was requested related to the lack of sliding scale coverage having been documented as given on the dates and time noted above. During an interview with the Director of Nursing on 8/12/11 at 9:00 a.m. she indicated she could not find any documentation to indicate the resident had received any insulin on the dates			

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	and times noted above. 3.1-35(g)(2)			
F0309 SS=E	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure insulin coverage and antihypertensive medications were given as ordered for 3 of 20 residents (Resident #'s 71, 73, and 60) reviewed for medication administration of as needed medication and failed to ensure readmission orders were properly transcribed to prevent medication errors for 1 of 4 residents (Resident #9) reviewed readmitted to the facility from the hospital in a Stage 2 Sample of 30. Findings include: 1.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension,	F0309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** 1A.RESIDENT #71 ASSESSED AND NO HARM NOTED. 1B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. RESIDENTS WITH PRN CLONIDINE ORDERS HAVE BEEN REVIEW TO ENSURE PROPER ADMINISTRATION OF MEDS. 1C. ALL NURSES WERE EDUCATED ON PROPER ADMINISTRATION OF PRN MEDICATIONS. (ATTACHMENT A) 1D. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD PRESSURE ORDERS TO ENSURE PROPER ADMINISTRATION OF PRN MEDICATIONS ON	08/29/2011

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	bipolar disorder, and chronic obstructive pulmonary disease. A health care plan problem, dated 6/1/11, indicated the resident had a diagnosis of hypertension and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, "Administer medications as ordered" and "Monitor blood pressure as ordered." A recapitulation of physician's orders, dated 7/6/11, indicated Resident #71 was to have her blood pressure taken 3 times daily. The orders indicated the resident was to receive Clonidine 0.1 mg [milligram] one tablet as needed if the resident's systolic b/p [blood pressure] was above 150 and her diastolic b/p was above 90. During a review of the June and July medication administration records (MAR) on the following dates and times, the residents b/p was elevated within the range for the as needed Clonidine to have been given: 6/29/11 at 10 p.m.- 167/98 7/15 at 10 p.m. - 170/94 7/17/11 at 10 p.m.-154/90 The MAR and nursing notes for these		SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) 2A. MEDICATION ERROR REPORT COMPLETED FOR RESIDENT #9 WITH PHYSICIAN NOTIFICATION. 2B.ALL RE-ADMITS HAVE THE POTENTIALTO BE AFFECTED. ALL RE-ADMISSION ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE PROPER TRANSCRIPTION OF ORDERS. (ATTACHMENT B) 2C. THE NURSES HAVE BEEN RE-EDUCATED ON PROPER TRANSCRIPTION OF ORDERS. (ATTACHMENT A) 2D. ALL RE-ADMISSION ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE PROPER TRANSCRIPTION OF ORDERS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B) 3A. GLUCOSE RESULTS WERE	

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	dates and times lacked any information related to the blood pressure medication having been given as ordered by the physician and/or any follow-up blood pressure reading having been taken. The following dates and times lacked any blood pressure having been taken to see if the blood pressure medication needed to be given: June 2 and 3, 2011 at 6 a.m. June 4 and 9, 2011 at 2 p.m. June 10, 13, 14, and 15, 2011 at 6 a.m. June 15, 2011 at 10 pm. June 17, 19, 20, 21, 2011 at 6 a.m. June 20 and 21, 2011 at 2 p.m. June 30, 2011 at 10 p.m. July 19, 2011 at 10 p.m. July 20, 21, 22, 2011 at 6 a.m. During an interview with the Administrator and Director of Nursing (DoN) on 8/11/11 at 8:20 a.m., additional information was requested related to the lack of medication having been given on the dates noted above or the blood pressure having been taken as ordered on the dates noted above. During an interview on 8/12/2011 at 11:30 a.m., the DoN indicated she		OBTAINED FROM 24 HOUR SHEETS AND PLACED ON CHART RECORD FOR RESIDENT #60. 3B. GLUCOSE MONITORING ORDERS WERE REVIEWED. NO CONCERNS NOTED AT THIS TIME. 3C.NURSES WERE EDUCATED NEW GLUCOSE MONITORING PROCEDURES. (ATTACHMENT A) 3D. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD GLUCOSE ORDERS TO ENSURE PROPER ADMINISTRATION OF SLIDING SCALE ORDERS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) 4A. GLUCOSE RESULTS WERE OBTAINED FROM 24 HOUR SHEETS AND PLACED ON CHART RECORD FOR RESIDENT #73 4B. GLUCOSE MONITORING ORDERS WERE REVIEWED.	

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	had no information to provide related to the medication having not been given and/or the blood pressure having been taken on the dates noted above. 2.) The clinical record for Resident # 9 was reviewed at 8/11/11 at 9:30 a.m. Diagnoses for Resident #9 included, but were not limited to, chronic leg cellulitis, venous stasis, congestive heart failure, alcoholic liver disease, anxiety , mental retardation and dementia. Resident #9 was readmitted from the hospital on 7/14/11 following treatment for cellulitis, alcoholic liver disease, and diabetes mellitus. Readmission orders sent with the resident included, but were not limited to, the following three orders as noted below: Levaquin (an antibiotic) 500 milligrams one daily for 21 days (the order indicated this med had been started on 6/16/11, which indicated the medication regimen should have been completed). This order was transcribed to the MAR to be given daily without note of any stop date. The times the medication was to be		4C. NURSES WERE EDUCATED ON NEW GLUCOSE MONITORING PROCEDURES. (ATTACHMENT A) 4D. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD GLUCOSE ORDERS TO ENSURE PROPER ADMINISTRATION OF SLIDING SCALE ORDERS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	given were documented in error for twice daily at 7 a.m. and 7 p.m.- The med was given twice daily for three days in error and then rewritten for once daily with a stop date now included for 8/3/11 (a 21 day time period). Fluticasone 0.05 % (a spray used for allergy relief) 2 sprays inhaled daily. This medication was transcribed to the MAR as "Fluticasone 0.5 % nasal spray 2 sprays each nostril daily" The time the medication was to be given was recorded in error for 7 a.m. and 8 p.m., not once daily. This medication was given twice daily through 8/11/11. Saline nasal spray (a moisture nasal spray) 1 spray each nostril several times daily. This medication was transcribed to the MAR as "Saline nasal spray 1 spray each nostril three times daily." The saline nasal spray was documented as having been given 3 times daily through 8/11/11. The clinical record lacked documentation of the Levaquin, Fluticasone, and/or Saline nasal spray having been clarified with the physician at the time of readmission and/or any other occasion. During an interview with the			

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	Administrator and Director of Nursing on 8/11/11 at 1:50 p.m., additional information was requested related to the Levaquin having been given for another 21 days and the errors in the Levaquin, Fluticasone nasal spray, and Saline nasal spray administration as noted above. During an interview with the Director of Nursing on 8/12/11 at 1:30 p.m., she indicated the nasal spray orders above had been clarified. She indicated she was still trying to find out whether the physician intended for the Levaquin to be restarted and given for another 21 days. 3.) The clinical record for Resident #60 was reviewed on 8/9/11 at 2:10 p.m. Resident # 60's current diagnoses included, but were not limited to, diabetes mellitus and dementia. Resident #60 had a health care plan, dated 4/21/11 which indicated the resident had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypoglycemia and hyperglycemia. Interventions for this problem included monitor blood sugars as ordered and administer medication as ordered.			

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	Resident # 60 had physician's orders for the following, A. Monitor blood sugar results 4 times daily at 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 3/31/10 B. Administer Lantus insulin 8 units subcutaneously at bedtime. This order originated on 2/8/10. C. Administer Novolog sliding scale insulin according to blood sugar results as listed below, 141 - 180 = 1 unit 181 - 220 = 2 units 221 - 260 = 4 units 261 - 300 = 6 units 301 - 340 = 7 units 341 - 380 = 8 units 381 - 420 = 9 units 421 - 460 = 10 units greater than 460 call the physician The sliding scale insulin orders originated on 3/31/10 Review of the July 2011 "Blood Glucose Monitoring Record" for Resident # 60 indicated the incorrect dose of insulin was documented as having been given on the following dates and times,			

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	July 1, 11:30 a.m., blood sugar result was 176, no insulin was documented as having been given. The resident should have received 1 unit. July 1, 4:30 p.m., blood sugar result was 171, no insulin was documented as having been given. The resident should have received 1 unit. July 1, 9:00 p.m., blood sugar result was 143, no insulin was documented as having been given. the resident should have received 1 unit. July 2, 11:30 a.m., blood sugar result was 209, no insulin was documented as having been given. The resident should have received 2 units. July 2, 4:30 p.m., blood sugar result was 234, no insulin was documented as having been given. The resident should have received 4 units. July 2, 9:00 p.m., blood sugar result was 141, no insulin was documented as having been given. The resident should have received 1 unit. July 3, 11:30 a.m., blood sugar result was 243, no insulin was documented as having been given The resident should have received 4 units.			

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	July 3, 4:30 p.m., blood sugar result was 226, no insulin was documented as having been given. The resident should have received 4 units. July 4, 11:30 a.m., blood sugar result was 243, no insulin was documented as having been given. The resident should have received 4 units. July 5, 11:30 a.m., blood sugar result was 145, no insulin was documented as having been given. The resident should have received 1 unit. July 6, 11:30 a.m., blood sugar result was 211, no insulin was documented as having been given. The resident should have received 2 units. July 6, 4:30 p.m., blood sugar result was 160, no insulin was documented as having been given. The resident should have received 1 unit. July 13, 11:30 a.m., blood sugar result was 146, no insulin was documented as having been given. the resident should have received 1 unit. During an interview with the Director of Nursing on 8/11/11 at 3:30 p.m. additional information was requested related to the lack of sliding scale			

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	coverage having been documented as given on the dates and time noted above. During an interview with the Director of Nursing on 8/12/11 at 9:00 a.m. she indicated she could not find any documentation to indicate the resident had received any insulin on the dates and times noted above. 4.) The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to, diabetes mellitus, morbid obesity and osteoarthritis. Resident #73 had physician's orders for the following, A. Metformin (an oral diabetic medication) 500 milligrams 1 orally daily. The original date of this order was 7/10/11. B. Monitor blood glucose levels before meals and at bedtime. 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 6/14/11. July 21, 2011 an order			

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	was received to decrease blood glucose monitoring to twice daily 6:30 a.m. and 4:30 p.m. C. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below, 100 -150 = 3 units 151 - 200 = 6 units 201 - 250 = 10 units 251 - 300 = 15 units greater than 300 call the physician. A health care plan, dated 6/4/11 indicated Resident #73 had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypo or hyperglycemia. Interventions for this problem included, monitor blood sugars as ordered and administer medication as ordered. **Review of the June and July 2011 "Blood Glucose Monitoring Record" forms for Resident #73 indicated the resident received the incorrect dose of insulin on the following dates and times,** **June 22, 4:30 p.m. blood sugar result was 102, no insulin was**			

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	documented as having been given, the resident should have received 3 units. **June 26, 6:30 a.m., blood sugar result was 101, no insulin was documented as having been given, the resident should have received 3 units.** **July 13, 6:30 a.m., blood sugar result was 100, no insulin was documented as having been given, the resident should have received 3 units.** **July 14, 9:00 p.m., blood sugar result was 126, no insulin was documented as having been given, the resident should have received 3 units.** **July 18, 11:30 a.m., blood sugar result was 114, no insulin was documented as having been given, the resident should have received 3 units.** During an interview with the Director of Nursing on 8/11/11 at 3:30 p.m. additional information was requested related to the lack of sliding scale coverage having been given on the dates and time noted above.			

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During an interview with the Director of Nursing on 8/12/11 at 9:00 a.m. she indicated she could not find any indication the resident had received insulin on the dates and times noted above.

5.) Review of the current undated facility policy, titled "Medication administration Policy and Procedure" provided by the Administrator on 8/12/11 at 8:00 a.m. indicated the following,

"Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations.

Procedure: ...

22. Medication administration will be recorded on MAR [medication administration record] or TAR [treatment administration record] after given...."
The current 1/14/09, revised policy "Hypoglycemia Treatment Procedure" was provided by the Administrator on 8/12/11 at 8:00 a.m. The procedure indicated nursing staff were to document: the results of the blood glucose test, notification of the

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	physician, notifications of responsible party, specific treatment used, resident's response to the treatment, and any follow up. The current 1/10, revised "Medication Administration Policy and Procedure" was provided by the Administrator on 8/12/11 at 8:00 a.m. The policy indicated the medication administration will be recorded on the MAR or TAR after given. 3.1-37(a)			
F0315 SS=E	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure each resident had an order for an anchored catheter currently in use for the resident (Resident #73), failed to ensure catheter tubing was not	F0315	**F315 NO CATHETER,PREVENT UTI,RESTORE BLADDER** - -	08/29/2011

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	allowed to lie on the floor (Resident #19), and failed to ensure each resident had catheter orders that included the size of the catheter and bulb for 4 of 5 (Resident #73, 18, 19, and 25) residents reviewed with anchored Foley catheters in a Stage 2 Sample of 30. Findings include: 1.) The clinical record for Resident #25 was reviewed on 8/10/11 at 3:00 p.m. The resident had current diagnoses which included, but were not limited to, acute renal failure, history of urinary tract infection, hydronephrosis, and history of bladder tumor. The resident was receiving hospice services. A recapitulation of physician's orders, signed 7/6/11, included, but was not limited to "Change catheter monthly and prn [as needed]". The original date of this order was 11/30/10. The order lacked any information related to the size of the catheter and bulb to be used for the resident. During an interview on 8/11/11 at 8:20 a.m., additional information was requested related to the size of the		1A. FOLEY CATHETER ORDER WAS IMMEDIATELY CLARIFIED FOR RESIDENT #25 1B. ALL RESIDENTS WITH CATHETER ORDERS WERE REVIEWED. 1C. NURSES WERE EDUCATED ON APPROPRIATE CATHETER ORDERS (ATTACHMENT A) 1D. ALL CATHETER ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE APPROPRIATE ORDER OBTAINED OBTAINED ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY 1 TIME WEEKLY, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B) 2A. FOLEY CATHETER ORDER WAS IMMEDIATELY CLARIFIED AND TUBING IMMEDIATELY REPOSITIONED FOR RESIDENT #19 2B. ALL RESIDENTS WITH CATHETER ORDERS WERE REVIEWED AND CATHETER TUBING WAS CHECKED FOR PROPER	

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	catheter and bulb to be used for Resident #25. On 8/11/11 at 2:00 p.m., the DoN provided a copy of a clarification order, dated 8/11/11, for Resident #25's catheter. The order indicated the resident was to have a size 18 French (fr) catheter with a 30 cubic centimeter (cc) bulb. 2.) The clinical record for Resident # 19 was reviewed on 8/11/11 at 3:00 p.m. Diagnoses included, but were not limited to, atonic bladder and urinary retention, diabetes mellitus, and history of urinary tract infection. A catheter assessment, dated 5/9/11, indicated the resident required the use of an indwelling catheter due to urinary retention and an atonic bladder. The assessment indicated the resident had required a 16 fr catheter with a 10 cc bulb. A recapitulation of physician's orders, dated 8/3/11, indicated Resident #19 was to have her catheter changed every month. The orders lacked any information related to the size of the catheter or the bulb that was to be used for the resident.		PLACEMENT. 2C. NURSES WERE EDUCATED ON APPROPRIATE CATHETER ORDERS AND TUBING PLACEMENT (ATTACHMENT A) 2D. ALL CATHETER ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE APPROPRIATE ORDER AND THAT CATHETER TUBING IS NOT DRAGGING ON FLOOR OBTAINED ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B & J) 3A. FOLEY CATHETER ORDER WAS IMMEDIATELY CLARIFIED FOR RESIDENT #18 3B. ALL RESIDENTS WITH CATHETER ORDERS WERE REVIEWED. 3C. NURSES WERE EDUCATED ON APPROPRIATE CATHETER ORDERS (ATTACHMENT A) 3D. ALL CATHETER ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE APPROPRIATE ORDER OBTAINED ON SCHEDULED	

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	During observations on 8/8/11 at 11:40 a.m. and 8/10/11 at 11:00 a.m., Resident #19 was up in her wheelchair and her catheter tubing was lying on the floor underneath her chair. During an interview with the Administrator and DoN on 8/11/11 at 8:20 a.m., additional information was requested related to the size of the catheter and bulb to be used for Resident #19 and they were notified of the observations of the catheter tubing on the floor. On 8/11/11 at 2:00 p.m., the DoN provided a copy of a clarification order, dated 8/11/11, for Resident #19's catheter. The order indicated the resident was to have a size 18 French (fr) catheter with a 30 cubic centimeter (cc) bulb. 3.) The clinical record for Resident #18 was reviewed on 8/11/11 at 2:00 p.m. Diagnoses for Resident #18 included, but were not limited to, hypertension, chronic urinary tract infection with urinary retention, dementia, osteoporosis, and transient ischemic		DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B) 4A. FOLEY CATHETER ORDER WAS IMMEDIATELY OBTAINED FOR RESIDENT #73 4B. ALL RESIDENTS WITH CATHETER ORDERS AND 4C. NURSES WERE EDUCATED ON APPROPRIATE CATHETER ORDERS (ATTACHMENT A) 4D. ALL CATHETER ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE APPROPRIATE ORDER OBTAINED ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B) RESULTS OF THESE REVIEWS WILL BE D ISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	attacks. A recapitulation of physician's orders, signed 8/3/11, included, but was not limited to "Place 18 f Foley catheter and change monthly due to neurogenic bladder." The original date of this order was 5/18/11. The order lacked any information related to the size of the bulb to be used for the resident. During an interview on 8/11/11 at 8:20 a.m., additional information was requested related to the size of the catheter and bulb to be used for Resident #18. On 8/11/11 at 2:00 p.m., the DoN provided a copy of a clarification order, dated 8/11/11, for Resident #18's catheter. The order indicated the resident was to have a size 18 French (fr) catheter with a 30 cubic centimeter (cc) bulb. 3.) The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to, diabetes mellitus, morbid obesity and osteoarthritis. Resident #73 was admitted to the			

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	facility on 6/14/11. Resident #73 had a health care plan, dated 6/24/11 which indicated the resident had a problem listed as, the resident requires the use of a Foley catheter due to, multiple wounds, incontinent of bowel and morbid obesity. During observation on 8/8/11 at 9:00 a.m. Resident #73 was in her room , in her bed. The resident had an anchored Foley catheter in place. The catheter urinary drainage bag was inside a privacy bag. The catheter was secured on the side of the resident's bed. **Review of Resident #73's clinical record on 8/8/11 at 1:30 p.m. indicated there was no physician's order for the anchored catheter to be continued upon admission to the facility. The transfer orders signed by the hospital physician prior to admission to the facility lacked any order for the anchored catheter to be maintained.** **The 1st note of any physician's order related to the resident having a catheter was a physician's telephone order, dated 6/25/1,**			

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	which indicated an order to flush the anchored catheter as needed and anchor new catheter if unable to maintain patency of the current catheter in place. **A physician's telephone order, dated 7/11/11 indicated the following, obtain a urinalysis and culture and sensitivity test related to resident complaints of burning and urinary urgency.** **A laboratory urinalysis test report, dated 7/12/11, indicated the resident had 4 plus blood, nitrates and moderate bacteria in her urine. The physician was called the test results and an order was received to administer Bactrim double strength (an antibiotic) 1 orally twice daily for 7 days to treat a urinary tract infection.** **During an interview with the Director of Nursing on 8/8/11 at 2:00 p.m. she indicated the resident was admitted to the facility from the hospital with a catheter in place. She indicated she could not find an order in the clinical record for the catheter to be maintained on admission to the facility. The Director of Nursing indicated the**			

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	nurse who was working when the resident was admitted to the facility should have clarified with the physician at the time of admission any orders for the anchored catheter. The current 9/05 "Foley Catheter Maintenance Procedure" was provided by the Administrator on 8/12/11 at 8:00 a.m. The procedure indicated the catheter tubing should not touch the floor. 3.1-41(a)(1) 3.1-41(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure interventions used to help prevent falls were in place as indicated in their plan of care for 2 of 6 residents reviewed for fall prevention in a Stage 2 Sample of 30. (Resident #18 and #53) Findings include: 1.) The clinical record for Resident #18 was reviewed on 8/11/11 at 2:00	F0323	**F323FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES** 1A. CALL LIGHT WAS IMMEDIATELY PLACED WITHIN REACH FOR RESIDENT #18 1B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL WERE VISUALIZED TO ENSURE APPROPRIATE CALL LIGHT PLACEMENT.	08/29/2011

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	p.m. Diagnoses for Resident #18 included, but were not limited to, hypertension, chronic urinary tract infection with urinary retention, dementia, osteoporosis, and transient ischemic attacks. During an interview on 8/8/11 at 2:10 p.m., a concerned family member for Resident #18 expressed concerns over the resident's call light frequently not being within reach for her to use to request assistance. A "Fall Risk Assessment", dated 7/11/11, indicated Resident #18 was a fall risk due to a history of falls, confusion, unsteady gait, and weakness. A health care plan problem, updated on 8/4/11, indicated Resident #18 was at risk for falls. One of the approaches to prevent falls was "call light in reach." During observation on 8/10/11 at 8:15 a.m., Resident #18 was up in her wheelchair in her room facing the door with her back to the bed. The resident's eyes were closed and she appeared to be dozing. The call light		1C. ALL STAFF WERE EDUCATED ON APPROPRIATE CALL LIGHT PLACEMENT. (ATTACHMENT C) 1D. DON/DESIGNEE WILL COMPLETE AUDIT CALL LIGHT PLACEMENT ON SCHEDULED DAYS OF WORK AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT J) 2A. ALARM WAS IMMEDIATELY PLACED ON RESIDENT #53 BED. 2B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL WERE VISUALIZED TO ENSURE APPROPRIATE ALARM PLACEMENT. 2C. ALL STAFF WERE EDUCATED ON APPROPRIATE ALARM PLACEMENT. (ATTACHMENT A) 2D. DON/DESIGNEE WILL COMPLETE AUDIT ALARM PLACEMENT ON SCHEDULED DAYS OF WORK AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT J)	

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	was lying on the bed behind the resident. During an observation on 8/10/11 at 10:00 a.m., Resident #18 had been transferred from the wheelchair and was now in her recliner with her feet elevated. The call light was still on the resident's bed, but was not within her reach. LPN #1 was summoned to the resident's room and the call light was placed within her reach at that time. 2.) The clinical record for Resident #53 was reviewed 8/10/11 at 8:45 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, leukemia, depressive disorder, and persistent mental disorder. A "Fall Risk Assessment", dated 6/14/11, indicated Resident #53 was a fall risk due to a history of falls, confusion, unsteady gait, and compliance issues. The clinical record indicated the resident fell on 7/8/11 at 10:25 p.m. when he attempted to get up and go to the bathroom without assistance of the staff.		RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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A health care plan problem, updated on 7/18/11, indicated Resident #53 was at risk for falls. One of the approaches to prevent falls was "sensor alarm in bed and wheelchair."

A physician's order, dated 7/17/11, indicated Resident #53 was to have a sensor alarm while in bed and wheelchair.

During an observation on 8/10/11 at 8:35 a.m., Resident #53 was lying in his bed. The resident was awake and had one foot off the edge of the bed. No alarm box was noted on the bed in order for the pressure pad to signal when pressure was removed from the pad. An alarm box was present on the resident's wheelchair in the room.

LPN #1 was summoned to the room on 8/10/11 at 8:37 a.m. She was unable to locate an alarm box on the resident's bed. She removed the alarm box from the resident's wheelchair and plugged the cord from the pressure pad into the alarm box.

LPN #1 indicated, at that time, the CNAs who put the resident into bed after breakfast, must have forgotten to move the alarm box from the chair to

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	the bed for use with that pressure pad. The current 9/05, "Interventions to Reduce Fall Risk" policy was provided by the administrator on 8/12/11 at 8:00 a.m. The policy indicated the call light should be placed in the resident's reach. The policy indicated an equipment intervention was an alarm attached to a chair or bed. 3.1-45(a)(2)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure residents with orders for as needed narcotic	F0329	**F329DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** 1. REVIEWED PRN FLOW	08/29/2011

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	pain medication were monitored for the administration of the medication for 3 of 5 residents reviewed with orders for as needed pain medication in a Stage 2 Sample of 30. (Resident #'s 61, 63, and 71) Findings include: 1.) The clinical record for Resident #61 was reviewed on 8/10/11 at 2:10 p.m. Diagnoses for Resident #61 included, but were not limited to, bipolar disorder, chronic back pain, depression, and chronic abdominal pain. Resident #61 had an order for Hydrocodone - APAP (a narcotic pain medication) 7.5-500 mg (milligrams), dated 3/8/11, one tablet three times a day prn (as needed) for pain. The "narcotic sign out sheets" for Resident #61 listed the dates and times the "as needed" Hydrocodone - APAP pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times: 6/13/11 at 11:30 a.m. 7/11/11 at 1:00 p.m.		SHEETS FOR RESIDENT #61, #63 & #71 FOR CURRENT APPROPRIATE DOCUMENTATION. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENTS MAR'S WERE CHANGED TO INDICATE "SEE PRN FLOW SHEET". 3. ALL NURSES HAVE BEEN EDUCATED REGARDING THE USE OF THE PRN FLOW SHEET. (ATTACHMENT A) 4. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH PRN MEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	7/19/11 at 4:30 p.m. The Medication Administration Record (MAR) and the PRN Medication Flow Sheet for June and July 2011 for Resident #61, lacked any information related to the Hydrocodone - APAP medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record. 2.) The clinical record for Resident #63 was reviewed on 8/11/11 at 9:50 a.m. Diagnoses for Resident #63 included, but were not limited to, urinary retention, benign prostatic hypertrophy (BPH), chronic kidney disease, and chronic pain. Resident #63 had an order for Oxycodone Hydrochloride (a narcotic pain medication) 5 mg (milligrams), dated 2/28/22, 1/2 a tablet every four hours prn (as needed) for pain. The "narcotic sign out sheets" for Resident #63 listed the dates and times the "as needed" Oxycodone			

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	HCL (hydrochloride) pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times: 6/19/11 at 11:30 a.m. 6/24/11 at 10:00 a.m. 6/26/11 at 8:00 a.m. 7/21/11 at 7:00 a.m. The Medication Administration Record (MAR) and the PRN Medication Flow Sheet for June and July 2011 for Resident #63, lacked any information related to the Oxycodone HCL medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record. 3.) During an interview with the Director of Nursing (DoN) on 8/12/11 at 8:50 a.m., additional information was requested related to the lack of documentation of administration of the narcotic pain medication on the dates and times noted above for Resident #61 and #63. During an interview on 8/12/11 at 10:33 a.m., the DoN indicated she			

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	had no additional information to provide related to the lack of documentation of administration of the narcotic pain medication signed out on the dates and times for Resident #61 and #63 noted above. 4.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. The clinical record indicated resident #71 had problems with pain management and had frequent complaints of generalized pain and pain in her knees and legs. A recapitulation of physician's orders, dated 7/6/11, indicated the resident had an order for Hydrocodone (with Acetaminophen) (a narcotic pain medication) 5/500 mg one tablet three times a day for pain. The resident also had a current order for Hydrocodone (with acetaminophen) 7.5/325 mg tab 1 every 4 hours as needed for pain. The "narcotic sign out sheets" for Resident #71 listed the dates and			

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	times the "as needed" Hydrocodone pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times: 7/16/11 at 8:00 p.m. 7/19/11 at 11:00 p.m. 7/20/11 at 9:30 p.m. 7/22/11 at 10:00 p.m. 7/25/11 at 6:00 p.m. and 10:00 p.m. The Medication Administration Records (MAR) for Resident #71, lacked any information related to the as needed Hydrocodone medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record. During an interview with the Consultant RN on 8/12/11 at 11:30 a.m., additional information was requested related to the lack of pain monitoring for the narcotic medication signed out for Resident #71 on the dates and time noted above. The facility failed to provide any additional information as of exit on 8/12/11.			

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	5. The current 1/10, revised "Medication Administration Policy and Procedure" was provided by the Administrator on 8/12/11 at 8:00 a.m. The policy indicated the medication administration will be recorded on the MAR [Medication Administration Record] or TAR [Treatment Administration Record] after given. The policy also indicated prn [as needed] medication administration must be authorized by a licensed nurse, after completing an assessment. Documentation should include non-pharmacological interventions attempted prior to resorting to medication administration. 3.1-48(a)(3)	F0329	**F329DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** 1. REVIEWED PRN FLOW SHEETS FOR RESIDENT #61, #63 & #71 FOR CURRENT APPROPRIATE DOCUMENTATION. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENTS MAR'S WERE CHANGED TO INDICATE "SEE PRN FLOW SHEET". 3. ALL NURSES HAVE BEEN EDUCATED REGARDING THE USE OF THE PRN FLOW SHEET. (ATTACHMENT A) 4. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH PRN MEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST	08/29/2011

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	155232	A. BUILDING 00 B. WING	08/12/2011

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure it was free from significant medication errors for 1 of 4 residents reviewed for administration of blood pressure medication as ordered by the physician related to elevated blood pressure readings in a Stage 2 Sample of 30. (Resident #71) Findings include: 1.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. A health care plan problem, dated 6/1/11, indicated the resident had a diagnosis of hypertension and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, "Administer medications as ordered" and "Monitor blood pressure as ordered." A recapitulation of physician's orders,	F0333	29, 2011 **F333RESIDENTS FREE OF SIGNIGICANT MED ERRORS** 1.RESIDENT #71 ASSESSED AND NO HARM NOTED. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. RESIDENTS WITH PRN CLONIDINE ORDERS HAVE BEEN REVIEW TO ENSURE PROPER ADMINISTRATION OF MEDS. 3. ALL NURSES WERE EDUCATED ON PROPER ADMINISTRATION OF PRN MEDICATIONS. (ATTACHMENT A) 4. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD PRESSURE ORDERS TO ENSURE PROPER ADMINISTRATION OF PRN MEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2	08/29/2011

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	dated 7/6/11, indicated Resident #71 was to have her blood pressure taken 3 times daily. The orders indicated the resident was to receive Clonidine 0.1 mg [milligram] one tablet as needed if the resident's systolic b/p [blood pressure] was above 150 and her diastolic b/p was above 90. During a review of the June and July medication administration records (MAR) on the following dates and times, the residents b/p was elevated within the range for the as needed Clonidine to have been given: 6/29/11 at 10 p.m.- 167/98 7/15 at 10 p.m. - 170/94 7/17/11 at 10 p.m.-154/90 The MAR and nursing notes for these dates and times lacked any information related to the blood pressure medication having been given as ordered by the physician and/or any follow-up blood pressure reading having been taken. During an interview with the Administrator and Director of Nursing (DoN) on 8/11/11 at 8:20 a.m., additional information was requested related to the lack of medication having been given on the dates noted above as ordered by the physician for		MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	elevated blood pressure readings. During an interview on 8/12/2011 at 11:30 a.m., the DoN indicated she had no information to provide related to the medication having not been given on the dates and times noted above. 3.1-48(c)(2)			
F0428 SS=E	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure the pharmacist noted and reported irregularities in regards to the administration of narcotics for 3 of 5 residents (Resident #61, #63, and #71) reviewed with physician's orders for as needed narcotic medication and failed to identify transcription errors made when a resident was readmitted to the facility from the hospital for 1 of 4 residents (Resident #9) reviewed readmitted to the facility	F0428	**F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON** 1-3A. REVIEWED PRN FLOW SHEETS FOR RESIDENT #61, #63 & #71 FOR CURRENT APPROPRIATE DOCUMENTATION. 1-3B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENTS MAR'S WERE CHANGED TO INDICATE "SEE PRN FLOW SHEET". 1-3C. ALL NURSES HAVE BEEN EDUCATED REGARDING THE	08/29/2011

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	from the hospital in a Stage 2 sample of 30. Findings include: 1.) The clinical record for Resident #61 was reviewed on 8/10/11 at 2:10 p.m. Diagnoses for Resident #61 included, but were not limited to, bipolar disorder, chronic back pain, depression, and chronic abdominal pain. Resident #61 had an order for Hydrocodone - APAP (a narcotic pain medication) 7.5-500 mg (milligrams), dated 3/8/11, one tablet three times a day prn (as needed) for pain. The "narcotic sign out sheets" for Resident #61 listed the dates and times the "as needed" Hydrocodone - APAP pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times: 6/13/11 at 11:30 a.m. 7/11/11 at 1:00 p.m. 7/19/11 at 4:30 p.m. The Medication Administration Record (MAR) and the PRN Medication Flow		USE OF THE PRN FLOW SHEET. (ATTACHMENT A) THE CONSULTING PHARMACIST HAS BEEN EDUCATED TO MEET WITH THE D.O.N. DURING EACH VISIT. 1-3D. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH PRN MEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT I) DURING CONSULTING PHARMACIST VISIT SHE WILL MEET WITH D.O.N./ DESIGNEE TO REVIEW RECOMMENDATIONS. 4A. MEDICATION ERROR REPORT COMPLETED FOR RESIDENT #9 WITH PHYSICIAN NOTIFICATION. 4B.ALL RE-ADMITS HAVE THE POTENTIALTO BE AFFECTED. ALL RE-ADMISSION ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE PROPER TRANSCRIPTION OF ORDERS. 4C. THE NURSES HAVE BEEN RE-EDUCATED ON PROPER	

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	Sheet for June and July 2011 for Resident #61, lacked any information related to the Hydrocodone - APAP medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record. The clinical record indicated the facility's pharmacy consultant had reviewed Resident #61's clinical record on 6/23/11 and 7/26/11. The pharmacy consultant gave no information/made no recommendations related to the discrepancies between the MAR, PRN Medication Flow Sheet, and the narcotic sign out sheets. 2.) The clinical record for Resident #63 was reviewed on 8/11/11 at 9:50 a.m. Diagnoses for Resident #63 included, but were not limited to, urinary retention, benign prostatic hypertrophy (BPH), chronic kidney disease, and chronic pain. Resident #63 had an order for Oxycodone Hydrochloride (a narcotic pain medication) 5 mg (milligrams),		TRANSCRIPTION OF ORDERS. (ATTACHMENT A) THE PHARMCIST WAS EDUCATED THAT SHE MUST MEET WITH D.O.N./DESIGNEE DURING EACH MONTHLY VISIT TO FACILITY. 4D. ALL RE-ADMISSION ORDERS WILL BE REVIEWED BY DON/DESIGNEE TO ENSURE PROPER TRANSCRIPTION OF ORDERS SCHEDULED WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS (ATTACHMENT B) THE PHARMCIST WILL REVIEW ALL RE-ADMISSION ORDERS TO ASSURE NO TRANSCRIPTION ORDERS DURING VISIT. RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	dated 2/28/22, 1/2 a tablet every four hours prn (as needed) for pain. The "narcotic sign out sheets" for Resident #63 listed the dates and times the "as needed" Oxycodone HCL (hydrochloride) pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times: 6/19/11 at 11:30 a.m. 6/24/11 at 10:00 a.m. 6/26/11 at 8:00 a.m. 7/21/11 at 7:00 a.m. The Medication Administration Record (MAR) and the PRN Medication Flow Sheet for June and July 2011 for Resident #63, lacked any information related to the Oxycodone HCL medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record. The clinical record indicated the facility's pharmacy consultant had reviewed Resident #63's clinical record on 6/23/11 and 7/26/11. The pharmacy consultant gave no information/made no			

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	recommendations related to the discrepancies between the MAR, PRN Medication Flow Sheet, and the narcotic sign out sheets. 3.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. The clinical record indicated resident #71 had problems with pain management and had frequent complaints of generalized pain and pain in her knees and legs. A recapitulation of physician's orders, dated 7/6/11, indicated the resident had an order for Hydrocodone (with Acetaminophen) (a narcotic pain medication) 5/500 mg one tablet three times a day for pain. The resident also had a current order for Hydrocodone (with acetaminophen) 7.5/325 mg tab 1 every 4 hours as needed for pain. The "narcotic sign out sheets" for Resident #71 listed the dates and times the "as needed" Hydrocodone pain medication was signed out for the resident. Included, but were not			

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	limited to, were the following dates and times: 7/16/11 at 8:00 p.m. 7/19/11 at 11:00 p.m. 7/20/11 at 9:30 p.m. 7/22/11 at 10:00 p.m. 7/25/11 at 6:00 p.m. and 10:00 p.m. The Medication Administration Records (MAR) for Resident #71, lacked any information related to the as needed Hydrocodone medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record. During an interview with the Consultant RN on 8/12/11 at 10:00 a.m., additional information was requested related to the lack of pain monitoring for the narcotic medication signed out for Resident #71 on the dates and time noted above. The facility failed to provide any additional information as of exit on 8/12/11. The clinical record indicated the consultant pharmacist reviewed the			

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	resident's clinical record on 7/26/11. During an interview with the Director of Nursing on 8/12/11 at 10:15 a.m., she indicated there were no pharmacy recommendations made related to the visit on 7/26/11. 4.) The clinical record for Resident # 9 was reviewed at 8/11/11 at 9:30 a.m. Diagnoses for Resident #9 included, but were not limited to, chronic leg cellulitis, venous stasis, congestive heart failure, alcoholic liver disease, anxiety , mental retardation and dementia. Resident #9 was readmitted from the hospital on 7/14/11 following treatment for cellulitis, alcoholic liver disease, and diabetes mellitus. Readmission orders sent with the resident included, but were not limited to, the following three orders as noted below: Levaquin (an antibiotic) 500 milligrams one daily for 21 days (the order indicated this med had been started on 6/16/11, which indicated the medication regimen should have been completed). This order was transcribed to the MAR to be given			

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	daily without note of any stop date. The times the medication was to be given were documented in error for twice daily at 7 a.m. and 7 p.m.- The med was given twice daily for three days in error and then rewritten for once daily with a stop date now included for 8/3/11 (a 21 day time period). Fluticasone 0.05 % (a spray used for allergy relief) 2 sprays inhaled daily. This medication was transcribed to the MAR as "Fluticasone 0.5 % nasal spray 2 sprays each nostril daily" The time the medication was to be given was recorded in error for 7 a.m. and 8 p.m., not once daily. This medication was given twice daily through 8/11/11. Saline nasal spray (a moisture nasal spray) 1 spray each nostril several times daily. This medication was transcribed to the MAR as "Saline nasal spray 1 spray each nostril three times daily." The saline nasal spray was documented as having been given 3 times daily through 8/11/11. The clinical record lacked documentation of the Levaquin, Fluticasone, and/or Saline nasal spray having been clarified with the physician at the time of readmission and/or any other occasion.			

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	During an interview with the Administrator and Director of Nursing on 8/11/11 at 1:50 p.m., additional information was requested related to the Levaquin having been given for another 21 days and the errors in the Levaquin, Fluticasone nasal spray, and Saline nasal spray administration as noted above. During an interview with the Director of Nursing on 8/12/11 at 1:30 p.m., she indicated the nasal spray orders above had been clarified. She indicated she was still trying to find out whether the physician intended for the Levaquin to be restarted and given for another 21 days. The clinical record indicated the consultant pharmacist reviewed the resident's clinical record on 7/26/11. During an interview with the Director of Nursing on 8/12/11 at 10:15 a.m., she indicated there were no pharmacy recommendations made related to the visit on 7/26/11. 5. The current undated "Consultant Pharmacist Monthly Reports" policy was provided by the Administrator on 8/12/11 at 8:00 a.m. The policy indicated the monthly consultation reports would document all aspects of			

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	the consultation visit, including the results of all medication administration record reviews. 3.1-25(h)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure nurses did not recontaminate their hands after hand washing for 1 of 5 nurses observed during	F0441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** 1A.NURSE IMMEDIATELY EDUCATED ON PROPER HAND WASHING TECHNIQUE.	08/29/2011

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	medication pass observations and failed to ensure soiled linens were not placed on the floor after removing them from beds for 1 of 2 observations. [LPN #1, Housekeeper #2] Findings include: 1. LPN #1 was observed passing medications at 11:01 a.m. on 8/9/11 to Resident #9. The LPN entered the resident's room and washed her hands. She dried her hands with paper towels and threw the paper towels away. She used her clean bare hands to turn off the faucet. She donned gloves and checked Resident #9's blood sugar. She removed the gloves and washed her hands. She turned the faucet off with her clean bare hands. LPN #1 was observed at 11:19 a.m. on 8/9/11, washing her hands. She turned the faucet off with her clean bare right hand. During an interview with the Director of Nursing on 8/11/11 at 3:45 p.m., she indicated the nurse should have used paper towels to turn of the faucet. The current undated "Handwashing		1B. NURSING STAFF EDUCATED ON HAND WASHING TECHNIQUE WITH REGARDS TO INFECTION CONTROL.(ATTACHMENT K) 1C. NURSING STAFF PERFORMED HAND WASHING TECHNIQUE. (ATTACHMENT K) 1D. DON/DESIGNEE TO COMPLETE AUDITS ON SCHEDULED DAYS OF WORK ON ALL SHIFTS DAILY TIMES ONE WEEK, 3X WEEKLY FOR 3 WEEKS, 2X WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS. (ATTACHMENT L) 2A. SOILED LINEN REMOVED FROM FLOOR AND HOUSEKEEPING STAFF IMMMEDIATELY EDUCATED. 2B. HOUSEKEEPING AND NURSING STAFF EDUCATED ON PROPER LINEN TECHNIQUE. (ATTACHMENT M) 2C. HOUSEKEEPING AND NURSING STAFF EDUCATED ON PROPER LINEN TECHNIQUE. (ATTACHMENT C) 2D. DON/DESIGNEE TO COMPLETE AUDITS ON SCHEDULED DAYS OF WORK DAILY TIMES 1 WEEK, 3X	

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	155232	A. BUILDING 00 B. WING	08/12/2011

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	Procedure" was provided on 8/12/11 at 12:35 p.m., by the Administrator. The Procedure indicated the faucets should be turned of with a paper towel and discarded after hands are washed. 2.) During observation on 8/8/11 at 1:00 p.m. housekeeping staff #2 was in room # 126 cleaning the resident's room. The complete set of bed linens from the 2 resident's beds in the room were in a pile on the floor. The linens were not in any type of bag. During an interview with housekeeping staff #2 at the time of the observation, she indicated she would put the linens in a bag when she was finished with the cleaning. The housekeeping staff continued to clean the room and did not place the linens in a bag. During an observation on 8/8/11 at 1:30 p.m. housekeeping staff #2 picked the linens up off the floor and placed them in a bag and removed the linens from the room. During an interview with the Director of Nursing on 8/11/11 at 3:30 p.m. she indicated linens should not be placed		WEEKLY FOR 3 WEEKS, 2X WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS. (ATTACHMENT H) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	on the floor. She indicated linens should be placed in bags when removed from the bed. **Review of the current facility policy, dated 9/05, titled "Bed Making (unoccupied) Procedure", provided by the director of nursing on 8/12/11 at 12:35 p.m. indicated,** **"Purpose: To prepare a bed for a resident who is not occupying it at the time, or for admission of a patient....** **4. Loosen soiled linen and roll from head to foot of bed and place in hamper or bag at foot of bed or in a chair." ...** **3.1-18(l)** **3.1-19(a)(1)**			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure blood sugar results and sliding scale insulin was documented in the clinical record for 1 of 3 residents reviewed with physician's orders for blood sugar monitoring and sliding scale insulin to be administered in a Stage 2 sample of 30. (Resident # 73) Findings include: 1.) The clinical record for Resident #73 was reviewed on 8/8/11 at 1:30 p.m. Resident #73's current diagnoses included, but were not limited to, diabetes mellitus, morbid obesity and osteoarthritis. Resident #73 had physician's orders for the following, A. Metformin (an oral diabetic	F0514	**F514 RES RECORDS-COMPLETE /ACCURATE/ACCESSIBLE** 1. FOR RESIDENT #73 GLUCOSE RESULTS WERE OBTAINED FROM 24 HOUR SHEETS AND PLACED ON CHART RECORD. 2. ALL RESIDENTS WITH GLUCOSE MONITORING ORDERS WERE REVIEWED. 3. NURSES WERE EDUCATED NEW GLUCOSE MONITORING PROCEDURES.(ATTACHMENT A) 4. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD GLUCOSE ORDERS TO ENSURE PROPER ADMINISTRATION OF SLIDING SCALE ORDERS ON SCHEDULED WORK DAYS DAILY TIMES 1 WEEK, 3X	08/29/2011

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	medication) 500 milligrams 1 orally daily. The original date of this order was 7/10/11. B. Monitor blood glucose levels before meals and at bedtime. 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 6/14/11. July 21, 2011 an order was received to decrease blood glucose monitoring to twice daily 6:30 a.m. and 4:30 p.m. C. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below, 151 - 200 = 6 units 201 - 250 = 10 units 251 - 300 = 15 units greater than 300 call the physician. A health care plan, dated 6/4/11 indicated Resident #73 had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypo or hyperglycemia. Interventions for this problem included, monitor blood sugars as ordered and administer medication as ordered. Review of the June and July 2011 "Blood Glucose Monitoring" records		WEEKLY FOR 3 WEEKS, 2X WEEKLY FOR 2 MONTHS AND RANDOM FOR 3 MONTHS. (ATTACHMENT I) RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS. CORRECTION DATE: AUGUST 29, 2011	

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	for Resident #73 lacked documentation of any blood glucose results on the following dates and times, June A. June 20, 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. B. June 30, 9:00 p.m. July A. July 7, 4:30 p.m. B. July 9, 4:30 p.m. C. July 11, 9:00 p.m. D. July 23, 4:30 p.m. E. July 24, 4:30 p.m. F. July 26, 6:30 a.m. and 4:30 p.m. G. July 27, 6:30 a.m. and 4:30 p.m. H. July 30, 6:30 a.m. and 4:30 p.m. During an interview with the Director of Nursing on 8/11/11 at 8:30 a.m. additional information was requested related to the lack of blood sugar results on the dates and times noted above,			

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	During an interview with the Director of Nursing on 8/11/11 at 3:10 p.m. she indicated all of the blood sugar results noted above were found documented on the nursing 24 hour report sheets. She further indicated the 24 hour report sheets were not a part of the clinical record. She indicated the nursing staff should have documented the results on the "Blood Glucose Monitoring Record" which is a part of the resident's record. 3.1-50(a)(1) 3.1-50(a)(2)			

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F0520 SS=D	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview, the facility's Quality Assessment and Assurance Committee failed to develop and implement appropriate plans of action to address deficient practices identified during the Annual Recertification and State Licensure survey related to transcription errors following readmission from the hospital (Resident #9) and pain assessment and monitoring related to narcotic medications signed out but not documented as given for 3 of 5	F0520	**F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS** 1.CONCERNS WERE IMMEDIATELY ADDRESSED. 2.CONCERNS WERE ADDED TO QA LOG FOR MONITORING. 3.AN ACTION PLAN WAS DEVELOPED FOR EACH AREA OF CONCERN. 4.AUDITS FROM ACTION PLANS WILL BE REVIEWED DURING QA MEETINGS. (ATTACHMENT B & I) QUARTERLY CHANGES WILL BE MADE AS NECESSARY TO ASSURE APPROPRIATE PLANS OF ACTION TO CORRECT IDENTIFIED QUALITY	08/29/2011

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	residents (Resident #'s 71, 63, and 61) reviewed for pain monitoring in a Stage 2 Sample of 30. Findings include: During an interview with the DoN and the Administrator on 8/12/11, at 8:50 a.m., the DoN indicated the facility had not identified the failure to ensure orders for a resident returning from a hospital were transcribed correctly for Resident #9 and had not identified the concerns related to narcotic pain medication administration for Resident #'s 71, 63, and 61 and no action plans had been developed to address these deficiencies. 3.1-52(b)(2)		DEFECENCIES. CORRECTION DATE: AUGUST 29, 2011	